HOUSE of REPRESENTATIVES
STATE OF MICHIGAN

Benefits Handbook

2015 - 2016

This handbook provides a summary of the benefits offered by the House of Representatives. This information is provided in summary form. Although the House of Representatives expects to continue such benefits and/or provisions, it reserves the right to modify, suspend or terminate them in whole or in part at any time.

For specific details regarding insurance coverage, limitations, and exclusions, please contact Human Resources. If there is any conflict between the information summarized here and the official plan, in all cases, the actual policy contract provisions will govern.

Table of Contents

House Benefits Overview

MEDICAL, INCLUDING RX

BCBSM Community Blue PPO Plan I
BCBSM Community Blue PPO Plan II
Simply Blue & Health Savings Account (H.S.A.)

VISION

Vision Service Plan (VSP) through BCBSM

DENTAL

Delta Dental Comprehensive Plan
Delta Dental Modified Plan

LIFE INSURANCE

Minnesota Life Insurance - two (2) times annual pay

DEPENDENT LIFE INSURANCE

Minnesota Life Insurance

LONG TERM DISABILITY (employees only)

Mutual of Omaha Insurance Company - 67% of bi-weekly, 90 day wait

PLAN YEAR - The plan year begins October 1, 2015 and ends September 30, 2016, this includes the Simply Blue Health Plan/Health Savings Account which has followed the calendar year in the past. Open enrollment for spending accounts, held in November, coincides with the calendar year and is managed by the State of Michigan.

Eligible employees may enroll, re-enroll or change their current enrollments in health (prescription drug included), dental, vision, life insurance and long term disability plans. Your benefit choices are selected and submitted on-line through HouseNet. If you do not make any changes, your coverage will remain the same as current year. If you are a newly hired eligible employee, you can enroll yourself and your eligible dependents 30 days after your hire date. Your selections will remain in effect for the remainder of the benefit year.

Member and employees contribute toward the House Benefit Plan through payroll deduction, see attached chart for rates. Eligible Members/employees may opt out of the entire Benefit plan and receive $2,990 or $115 per pay period (to receive the $2,990 persons must opt out of the entire plan). Employees may choose to opt out of individual plans, but will not receive opt-out dollars. Members and employees who opt-out of the House Benefit Plan or any medical plan must sign an opt-out declaration (see Appendix 2).

MEDICAL PLANS

MEDICAL COVERAGE is provided to you by the House to help pay for a wide range of health care services. The plan assists you with both minor medical costs and large medical expenses. The Medical Coverage Options chart provides detailed plan information.

PLAN TERMS

- **Deductible** - the amount you pay annually before services are covered
- **Co-Insurance** - the percentage or portion of expenses you pay
- **Annual Out-of-Pocket** - the maximum you would pay in a plan year for eligible medical expenses, including your deductible, office visit co-payments and prescription drug co-payments.

BCBSM COMMUNITY BLUE PPO MEDICAL COVERAGE - PLAN 1

Community Blue, offered through Blue Cross and Blue Shield of Michigan (BCBSM), is a preferred provider organization (PPO) with out-of-network options. Members of Community Blue do not have to choose a primary care physician, but may use any physician in the Community Blue network and receive the program's benefits. The physician network includes over 17,000 physicians statewide. In addition, plan participants may also use physicians outside of the Community Blue network and still receive benefits at a reduced level.

Community Blue PPO offers in-network preventive services with no co-pay while also offering treatment of illness and injury, with the nationwide recognition of the BCBSM logo on the identification card.

The advantages of this program are that it allows some of the freedom of choice allowed by traditional insurance plans, while reducing the amount of paperwork members have to complete for reimbursement of services. It offers the convenience and benefit level of an HMO, while still allowing out-of-network services. And, for those employees who have family members outside of the Lansing area, it offers flexibility.

BCBSM COMMUNITY BLUE PPO MEDICAL COVERAGE - PLAN 2

Community Blue PPO offers the same high level of coverage as PPO Plan 1 but comes at a lower, bi-weekly cost to the Member/employee while carrying a higher deductible and out-of-pocket copay maximums.

SIMPLY BLUE MEDICAL COVERAGE WITH HEALTH SAVINGS ACCOUNT

Blue Cross Blue Shield of Michigan offers a high deductible health care option (Simply Blue) to serve in conjunction with a health savings account. This option offers health coverage at a reduced cost for both the employer and employee.

In a health savings account, funds are contributed into an account which are not subject to federal income taxes at the time of deposit. Unlike a flexible spending account, funds roll over and accumulate year-to-year, if not spent. H.S.A.s are owned by the individual and may be used to pay for qualified medical expenses at any time without tax liability or penalty. Both the employer and employee may contribute to the account up to combined annual maximums of $3,300 for single coverage and $6,550 for two person and family coverage.

For details on specific covered services, please see the Medical Coverage Options chart.

DEPENDENT COVERAGE

Coverage in a House Benefit Plan is available for you and any eligible enrolled dependents. The Federal Health Care Reform Law extends eligibility for medical and prescription drug coverage to married and unmarried children of the covered employee until the end of the calendar year in which the child turns 26. IRS regulations extend all health coverage, including dental and vision, to dependents between the ages of 19-25, if the individual meets the IRS qualifications of a "dependent" (see Appendix 1).

NO COVERAGE

If you are covered by another medical plan and it adequately meets you and your family's health care needs, you may want to select the "No Coverage" option. Members and employees who opt-out of the House Benefit Plan or any Medical Plan must sign an opt-out declaration (see Appendix 2).

MID-YEAR CHANGES

Should you have a change in family status (which includes: marriage, birth, adoption, death, divorce or a change in spouse's employment status), you can make changes in your benefit selections at the time of the change in status to the extent that federal regulations allow. **You must notify the Human Resources Office within 30 days of a family status change.**

BCBSM PRESCRIPTION DRUG PLAN

(included in each medical plan)

Prescription drug coverage is an important part of your health care coverage. The House provides a prescription drug plan that incorporates a co-payment for each prescription filled.

ABOUT THE PLAN

The Prescription Drug Plan is a separate benefit administered by Blue Cross and Blue Shield of Michigan (BCBSM). In order to receive the maximum available benefit, you will be required to purchase your prescriptions from the Blue Cross and Blue Shield of Michigan Preferred Prescription Network of Pharmacies. If you go outside the network, you will be reimbursed 75% of the approved amount after your co-pay. The plan covers prescriptions which require a physician's prescription order.

PPO #1 AND PPO #2

TIER 1 $15 co-pay for generic or prescribed over the counter drugs

These drugs have a proven record of safety and effectiveness and offer the best value. Tier 1 drugs require the lowest co-payment, making them your most cost effective option for treatment. All generic drugs are formulary preferred.

TIER 2 $30 co-pay for formulary brand-name drugs

These brand-name drugs have a record of safety and effectiveness. Because more cost-effective therapy or a generic alternative is usually available, drugs in Tier 2 require a higher co-payment.

TIER 3 $50 co-pay for non-formulary brand-name drugs

Non-formulary brand-name drugs are not included in the BCBSM Custom Formulary. Tier 3 drugs may not have a proven record for safety or their clinical value may not be as high as the drugs in Tier 1 or Tier 2. Formulary alternatives are available.

SIMPLY BLUE / HEALTH SAVINGS ACCOUNT (co-pays apply after deductible is met)

TIER 1 $10 co-pay for generic or prescribed over the counter drugs

These drugs have a proven record of safety and effectiveness and offer the best value. Tier 1 drugs require the lowest co-payment, making them your most cost effective option for treatment. All generic drugs are formulary preferred.

TIER 2 $60 co-pay for formulary brand-name drugs

These brand-name drugs have a record of safety and effectiveness. Because more cost-effective therapy or a generic alternative is usually available, drugs in Tier 2 require a higher co-payment.

Note: If your prescription is filled by any type of network pharmacy, and you request the brand-name drug when a generic equivalent is available on the BCBSM MAC list and the prescriber has not indicated "Dispensed As Written" (DAW) on the prescription, you must pay the difference in cost between the brand-name drug dispensed and the maximum allowable cost for the generic plus the applicable co-payment.

90-DAY RETAIL PHARMACY BENEFIT

This allows you to receive a 90-day prescription refill from participating pharmacies for the same co-pay as the current 30-day refill. You must be on your medication for a period of at least 60 days out of the past 120 days before using this option.

MAIL ORDER PRESCRIPTION DRUGS

A mail order program is available to anyone who enrolls in the BCBSM Standard Prescription Drug Plan. This program is designed to reduce expenses and provide maintenance prescriptions that you and your family need on an ongoing basis. The mail order program provides maintenance prescription medications used to treat chronic conditions such as arthritis, diabetes, high blood pressure, asthma, etc. When utilizing the mail order program, you pay a $15 (generic), $30 (brand name) or $50 (non-formulary) co-payment.

When ordering your prescription(s) through the mail, there are no claim forms to file and no waiting for reimbursement. Your medication is delivered free of charge via the U.S. Postal Service or UPS (signature required for controlled substances). You will receive your medication within 10 to 14 days from the date your order is postmarked, along with a new prescription request card. Go to https://www.express-scripts.com for more information.

VISION PLAN

VSP Vision Plan - The vision plan provides coverage for you and your dependents in maintaining proper eye care. VSP provides an annual vision exam with a $5 co-pay. The plan provides either glasses or contact lenses. The benefit for glasses requires a $10 co-pay for lenses and up to $130 for eyeglass frames. The benefit for contact lenses which are medically necessary (the recipient is unable to wear eyeglasses) requires a $10 co-pay. For contact lenses which are not medically necessary, a maximum of $130 is paid to participating providers.

COVERED SERVICES

- Vision Examinations
- Testing for Glaucoma
- Lenses for Correcting Vision
- Eyeglass Frames

DENTAL PLAN

DELTA DENTAL PLAN

The dental plan provides four types of services.

- **Class 1 Benefits** - includes diagnostic and preventive services such as examinations and cleanings.
- **Class 2 Benefits** - includes x-rays, fillings, oral surgery, crowns, periodontic and endodontic procedures.
- **Class 3 Benefits** - includes procedures for construction of bridges and partial and complete dentures.
- **Class 4 Benefits** - includes orthodontic services to remedy an imperfection of the bite.

DENTAL PLAN		
PLAN SERVICES	**COMPREHENSIVE PLAN**	**MODIFIED PLAN**
Class 1 Benefits	100%	50%
Class 2 Benefits	90%	50%
Class 3 Benefits	50%	50%
Class 4 Benefits	50%	50%
Annual Max - Class 1, 2, 3	$1,500	$1,000
Life Max - Class 4	$2,000	$1,000

EMPLOYEE LIFE INSURANCE

Group term life insurance is provided through Minnesota Life, and is administered by the State of Michigan, Department of Civil Service, Benefits Division. **If you are covered under more than one plan of life insurance provided by the State of Michigan, your amount of coverage will only be that of the plan providing the highest amount of coverage. The State of Michigan plan includes the following: House of Representatives, Office of Retirement Services, Civil Service, etc.** Benefit coverage is at two (2) times pay (maximum benefit of $200,000).

If you opt out of the House Benefit Plan you cannot purchase Dependent Life Insurance. In addition, you will be automatically disqualified from participation in the Accidental Duty Death coverage, which is available at no cost. If you retire from House employment during the coming plan year under the Defined Benefit plan, your level of employee life insurance (up to two times salary) at the time of retirement will affect the life insurance coverage you will have as a State of Michigan Retiree (contact Human Resources for more information).

TAX CONSIDERATIONS

Current federal tax law states that the first $50,000 of employer-paid life insurance protection is not subject to taxes. Amounts in excess of $50,000 are taxable. The government assigns a value to these amounts and this value is added to your W-2 earnings. These amounts are called imputed income. This is the amount which would be shown on your W-2 form and on your bi-weekly statement of earnings as "taxable benefits". Current federal tax law also states that benefits received in the event of your death are not taxable to your beneficiaries.

ACCIDENTAL DUTY DEATH

This coverage is provided in addition to the Employee Life Insurance coverage which is a part of the House Benefit plan. This coverage pays $100,000 to your beneficiary in the event of your death resulting from accidental personal injuries arising out of or in the course of your employment with the House (This does not include traveling between work and your home). **To be covered, you must be enrolled in the Employee Life plan.**

DEPENDENT LIFE INSURANCE

Dependent Life Insurance is an optional benefit available to assist you should you experience the death of an enrolled family member (spouse or a dependent child) and you are faced with unexpected expenses. In order to participate in Dependent Life Insurance coverage, you must also be covered for Employee Life Insurance. If you are married to a State/Legislative employee or retiree who also has Employee Life Insurance, you cannot cover your spouse as a dependent for Dependent Life Insurance. Children can be covered by either parent, but not both. Options are listed below:

- $25,000 spouse and/or $10,000 per child
- $10,000 spouse and/or $5,000 per child
- $5,000 spouse and/or $2,500 per child
- $1,500 spouse and/or $1,000 per child
- $10,000 child(ren)
- No Coverage

If you do not select coverage for your dependents when you are first eligible, you may enroll only during subsequent annual enrollments, subject to evidence of good health or after a life event. Your lawful spouse and your unmarried children are eligible. Children are covered from fourteen days after birth up to their twenty-third birthday. The definition of children includes legally adopted children, stepchildren who live with you and children under your legal guardianship who are living with you and are chiefly dependent on you for support.

Dependent coverage is part of the House's Benefit plan for elected Members. Eligible employees have the option to purchase coverage.

LONG TERM DISABILITY INSURANCE

The House Benefit Plan includes Long Term Disability coverage for participating employees which provides income in the event you are disabled and unable to work. A disability is an injury or illness which initially prevents you from performing your normal job. Benefits may continue until you recover, reach age 65, or upon death. Disabilities which begin after age 60 are paid for varying lengths of time, depending on the age you become disabled. **Long term disability coverage is not available to Representatives.**

OPTIONS

The Long Term Disability plan provides you a benefit equivalent to 66 2/3% of your pay after a 90 day wait from the onset of your disability. The amount of insurance is determined by your annual rate of pay as of the eligibility cutoff date for the plan year and remains unchanged for the plan year. The maximum monthly benefit is $6,381, and other benefits you receive may reduce the amount of your long term disability benefit.

PRE-EXISTING CONDITIONS

A pre-existing condition means any injury or illness for which a covered employee received medical treatment, advice, consultation, care or services including diagnostic measures, or had drugs or medicines prescribed or taken in the 3 months prior to the day the covered employee became insured under the policy. The policy will not provide benefits for disability caused by, contributed to by, or resulting from a pre-existing condition; and which begins in the first 12 months after the covered employee is continuously insured under the policy.

TAXATION OF LTD BENEFITS

Any amounts of disability pay received through an insurance policy that is part of an employer's benefits program are included in the employee's gross income to the extent such amounts were attributable to contributions made by the employer and not included in the employee's gross income. Contributions by the employer may include insurance premiums paid or payments made to a separate trust or insurance fund. Therefore, if an employer pays 100% of insurance premiums for a disability policy maintained on behalf of all employees, the disability benefits when received, are included in the employee's gross income and are subject to standard income tax.

OTHER BENEFITS

DEFERRED COMPENSATION

Separate from your House Benefits, the State of Michigan currently provides the following plans to help you save for retirement: 401(k) Plan, Roth 401(k) Plan, and 457 Plan.

The 457 and 401(k) plans allow you to set aside part of your current salary in before-tax dollars (Social Security taxes are deducted) and defer taxes until retirement when you will potentially be in a lower tax bracket. With the Roth 401(k), your contributions are taxed before being put in your account. As long as you don't withdraw from your Roth 401(k) account for at least five years and before the age 59 ½, you do not pay any more taxes on your contributions or investment earnings. Review the plans carefully to learn each plans special features. For more information, visit the following website (https://stateofmi.voyaplans.com).

SPARROW CARES "EMPLOYEE ASSISTANCE PROGRAM"

517-364-2626 OR **1-800-234-4191**

CARES is an employee benefit designed to provide professional assistance for a wide range of personal problems to associates and their household members. CARES helps with virtually any personal problem that you or a household member might have. Most often, the problems dealt with are alcohol and drug abuse, divorce and other family disputes, stress and other psychological and emotional matters, and financial and legal problems. Evaluation of your personal problem and short-term counseling is FREE. If long-term counseling or other help is needed, CARES can assist in making an appropriate referral. CARES services are completely private, and all contracts with CARES are kept entirely confidential. Only you can decide who will know about your participation. The CARES program is available 24 hours a day, 365 days a year. It is personal, confidential and very professional.

BENEFITS CONTINUATION COVERAGE NOTICE

Under federal law, the Michigan House of Representatives is required to offer employees and covered family members the opportunity for a temporary extension of health coverage (called "Continuation Coverage") at group rates where coverage under the plan would otherwise end due to certain qualifying events. This notice is intended to provide you and any covered dependents with a summary of your rights and obligations under the continuation coverage provisions of the law.

Qualifying Events for Covered Employee - If you are an employee of the Michigan House of Representatives covered by our group health plan, you may have the right to choose this continuation coverage if you lose your group health coverage because of the termination of your employment (for reasons other than gross misconduct) or a reduction in your work hours.

Qualifying Events for Covered Spouse - If you are the spouse of an employee of the Michigan House of Representatives and are covered by our group health plan, you may have the right to choose continuation coverage for yourself if you lose group health coverage under the plan for any of the following reasons:

1. A termination of your spouse's employment (for reasons other than gross misconduct);
2. A reduction in your spouse's hours;
3. The death of your spouse;
4. Divorce or legal separation from your spouse; or
5. Your spouse becomes entitled to Medicare.

Qualifying Events for Covered Dependent Children - If you are the covered dependent child of an employee covered by our group health plan, you may have the right to continuation coverage for yourself if group health coverage under the plan is lost for any of the following reasons:

1. A termination of the employee's employment (for reasons other than gross misconduct);
2. A reduction in the employee's hours of employment;
3. The death of the employee;
4. Employee's divorce or legal separation;
5. The employee becomes entitled to Medicare; or
6. You cease to be a "dependent child" under the terms of the health plan.

IMPORTANT - Employee, Spouse, and Dependent Notifications Required

Under the law, the employee, spouse, or other family member has the responsibility to inform the Human Resources Office of a divorce, legal separation, or a child losing dependent status under our group health plan. This notification must be made within 60 days from the date of the event or the date on which coverage would end, whichever is later. If this notification is not completed in a timely manner, rights to continuation coverage may be forfeited.

Election Period and Coverage - Once the Human Resources Office is notified that a qualifying event has occurred, the Human Resources Office will, in turn, notify covered individuals (also known as qualified beneficiaries) of their right to elect continuation coverage. Each qualified beneficiary has independent election rights and will have 60 days from the date coverage is lost under the plan or the date of notification, whichever is later, to elect continuation coverage. If a qualified beneficiary does not elect continuation coverage within this election period, then rights to continue insurances will end.

If a qualified beneficiary elects continuation coverage and pays the applicable premium, the Michigan House of Representatives is required to provide the qualified beneficiary with coverage that is identical to the coverage provided under the plan to similarly situated employees and/or covered dependents.

Length of Continuation Coverage - 18 Months. If the event causing the loss of coverage is a termination of employment (other than for reasons of gross misconduct) or a reduction in work hours, then each qualified beneficiary will have the opportunity to continue coverage for 18 months from the date of the qualifying event.

Social Security Disability - The 18 months of continuation coverage can be extended to 29 months if the Social Security Administration determines that a qualified beneficiary was disabled at any time within the first 60 days of continuation coverage according to Title II or XVI of the Social Security Act. It is the qualified beneficiary's responsibility to obtain this disability determination from the Social Security Administration and notify the Human Resources Office within 60 days of the date of determination and before the original 18 month period expires. It is also the qualified beneficiary's responsibility to notify the Human Resources Office within 30 days that a final determination has been made that they are no longer disabled.

Secondary Events - An extension of the 18 months of continuation coverage can occur if, during the initial 18 months of continuation coverage, a second event takes place (divorce, legal separation, death, Medicare entitlement, or a dependent child ceasing to be a dependent). If a second event does take place, then the 18 months of continuation coverage can be extended to 36 months from the date of the original qualifying event date for the qualified beneficiary spouse and/or dependent children. If a second event occurs, it is the qualified beneficiary's responsibility to notify the Human Resources Office. In no event, however, will continuation coverage last beyond three years from the date of the original qualifying event.

Length of Continuation Coverage - 36 Months. If the original event causing the loss of coverage was the death of the employee, divorce, legal separation, Medicare entitlement, or a dependent child ceasing to be a dependent child, each qualified beneficiary will have the opportunity to continue coverage for 36 months from the date of the qualifying event.

Eligibility, Premiums, and Potential Conversion Rights - A qualified beneficiary does not have to show that he/she is insurable to elect continuation coverage. The Michigan House of Representatives, however, reserves the right to verify eligibility status and terminate continuation coverage retroactively if you are determined to be ineligible or if there has been a material misrepresentation of the facts. A qualified beneficiary may have to pay all of the applicable premium plus a 2% administration charge for continuation coverage. These premiums may be adjusted in the future if the applicable premium amount changes. In addition, if continuation coverage is extended from 18 months to 29 months due to a Social Security disability, the Michigan House of Representatives can charge up to 150% of the applicable premium during the extended coverage period. There is a grace period of 30 days for the regularly scheduled monthly premiums. At the end of the 18 months or 36 months of continuation coverage, a qualified beneficiary must be allowed to enroll in an individual conversion plan if such a conversion is available.

Notification of Address Change - To ensure that all covered individuals receive information properly and efficiently, it is important that you notify the Human Resources Office of any address change as soon as possible. Failure on your part to do so may result in delayed notifications or a loss of continuation coverage options.

Cancellation of Continuation Coverage - The law provides that if elected and paid for, continuation coverage may end prior to the maximum continuation period for any of the following reasons:

1. The Michigan House of Representatives ceases to provide a group health plan to any of its employees;

2. Any required premium for continuation coverage is not paid in a timely manner;

3. A qualified beneficiary becomes covered under another group health plan that does not contain any exclusion or limitation with respect to any pre-existing condition of such beneficiary, other than an exclusion or limitation which does not apply to (or is satisfied by) such beneficiary by reason of the Health Insurance Portability and Accountability Act of 1996;

4. A qualified beneficiary becomes entitled to Medicare;

5. A qualified beneficiary has extended coverage to 29 months due to a Social Security disability and a final determination has been made that the qualified beneficiary is no longer disabled;

6. A qualified beneficiary notifies the Human Resources Office that they wish to cancel continuation coverage.

Contact Information

HUMAN RESOURCES
517-373-3069
10th Floor House Office Building

BLUE CROSS & BLUE SHIELD OF MICHIGAN
Group # 007001928
1-877-354-2583
www.bcbsm.com

DELTA DENTAL PLAN OF MICHIGAN
Group #1750-0001 & 0002
1-800-482-8915
www.deltadentalmi.com

SPARROW CARES "EMPLOYEE ASSISTANCE PROGRAM"
517-364-2626 or 1-800-234-4191

VOYA-DEFERRED COMPENSATION PLAN MANAGER
800-748-6128
https://stateofmi.voyaplans.com

Appendix 1

DEPENDENT AND ADULT CHILDREN ELIGIBILITY GUIDELINES

ELIGIBLE DEPENDENTS

Eligible dependents may be enrolled in your health, dental, and vision plans. Dependents include your spouse and any of your unmarried children until the end of year of age 19. In addition to being unmarried, children must meet the following conditions to be considered eligible:

- Your child by birth, legal adoption or legal guardianship.
- In the case of legal adoption, a child is eligible for coverage as of the date of placement. Placement occurs when you become legally obligated for the total or partial support of the child in anticipation.
- Step-child(ren) is eligible for health coverage. To receive dental and vision coverage, a step-child must live with the employee at least 50% of the time and the employee must provide at least 50% of the child's support.
- Foster child(ren) placed in your home by a State agency or the court.
- Your child(ren) from the age of 19 until the end of year of age 25 who are enrolled in an accredited educational institution and for whom you provide at least 50% of their support. If such an enrolled dependent takes a leave of absence from studies due to a medical necessity, as certified by a physician, coverage will not be discontinued during the first year of the absence, unless the dependent turns 25.

DEPENDENT LIFE INSURANCE

Eligible dependents are unmarried children between the ages of 14 days and 23 years for whom you provide at least 50% of their support. These dependents are not required to be enrolled in school. Your spouse is also eligible if he or she is not a State employee or State retiree.

ELIGIBLE ADULT CHILDREN (Health Only)

Under recent changes to the federal law, eligible children up to age 26 may be enrolled in your health coverage, regardless of marital or student status or dependency upon you for support. Coverage does not extend to dental or vision plans or to his or her spouse or children. To be eligible for health coverage, your adult child must meet one of the following criteria:

- Your child(ren) by birth, legal adoption, or legal guardianship.
- Step-child(ren).
- Foster child(ren) placed in your home by a State agency or the court.

COVERAGE FOR INCAPACITATED CHILDREN

Incapacitated children are those who are unable to earn a living because of mental disability or physical disability and must depend on their parents for support and maintenance. If your enrolled dependent is deemed an incapacitated child, the coverage for this child will continue beyond age 19 as long as:

- He or she became incapacitated before age 19.
- Documentation verifying the child's condition was provided to the insurance carrier prior to the child becoming 19.
- The child continues to be incapacitated, and
- Your coverage does not terminate for any other reason.

CANCELING DEPENDENT OR ADULT CHILD COVERAGE

You must immediately notify Human Resources to cancel your dependent or adult child coverage when he or she no longer meets the definition of an eligible dependent or adult child. Ex-spouses are not eligible and must be removed from coverage effective the date of divorce.

Appendix 2

HOUSE of REPRESENTATIVES
STATE OF MICHIGAN

HUMAN RESOURCES/ 10 SOUTH

Health Care Coverage Waiver Declaration

EMPLOYEE NAME

On behalf of myself and my eligible dependents (if any), I waive the option to enroll in the Michigan House of Representatives Health Care Plan (the "Plan") offered at this time for the following reason:

- I am covered under another plan as a spouse or dependent. I understand that I will have to wait until next open enrollment to participate in the Plan unless I experience a change event (as explained in the **Notice of Enrollment Rights** below).

- I do not wish to participate in the Plan at this time, but am not covered by another plan. I understand that I will have to wait until next open enrollment or a family status change as provided in the Internal Revenue Code (i.e., marriage, birth, adoption or divorce) to participate in the Plan.

If you are declining to enroll in the Plan at this time because of other health insurance coverage, please provide the following information:

SUBSCRIBER NAME

CARRIER NAME | GROUP/POLICY NUMBER

I affirm that the assertions in this form are true and complete to the best of my knowledge.

EMPLOYEE SIGNATURE | DATE

EMPLOYER SIGNATURE | DATE

NOTICE OF ENROLLMENT RIGHTS

If you are declining enrollment for yourself and your dependents (including your spouse) because of other health insurance coverage, you may in the future be able to enroll yourself and your dependents in the Plan, provided that you request enrollment within 30 days of your coverage involuntarily ending (or cessation of employer contributions). In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents, provided that you request enrollment within 30 days of the marriage, birth, adoption, or placement for adoption.